Medicaid Cost-Drivers Forum
April 26, 2010
Summary/Takeaways

1. Kansas, like most other states, faces an economic imperative to control costs in Medicaid. That imperative is amplified by the recent passage of federal health reform. Additional across-the-board rate cuts like those imposed in November are not an option, and the existing cuts may not be sustainable. Federal restrictions also prevent the state from reducing enrollment through changes in eligibility standards. It is also difficult to save money through optional services because optional services are often a lower-cost substitute for mandatory services, and because more services will be mandatory when federal reforms are implemented in 2014.Therefore, savings have to be found elsewhere by reducing the overall cost of the care provided.

2. The Kansas Health Policy Authority has identified care for the aged and disabled populations as a significant factor driving up the cost of Medicaid. Controlling future growth in Medicaid expenditures will require changes in the way services for these high-risk, high-cost populations are managed and coordinated.

3. The enactment of federal health reform will soon make Medicaid the single largest provider of health coverage in the United States. This increases the risks of Medicaid cost growth. It also means that the choices Medicaid makes and the policies it pursues could have a profound impact on the entire health care system as a whole.

4. Several options exist for improving care management and coordination, such as:

    a. paying a flat rate for services representing a single episode or course of treatment that can be bundled together, such as outpatient care;
    b. implementing a medical home model of care delivery;
    c. extending care coordination to high-cost populations to manage medication use and reduce hospitalizations; and
    d. expanding the use of health information technology and exchange (HIT/HIE).

5. KHPA staff and participants in the forum seem to agree there is also a need for better coordination of physical and mental health services since many people in the aged and disabled population groups suffer from both sets of conditions.

6. There is concern among providers, especially those in the mental health field, that managed care will only result in payment reductions and service limitations, not in better management and coordination of care. Their experience with early forms of managed care in the private sector (HMO's) shapes their skepticism. Providers would like to have meaningful input in the process of designing and selecting the model to be used.

7. The goals of any managed care model for these populations should be based on measurable standards of cost efficiency and quality improvement. Many projections of cost savings are considered "soft" and unreliable.

8. HCBS care provides some opportunity for savings, at least when compared to the cost of institutional care, but also presents challenges in terms of management. Services should be tailored to the individual's need and be managed for both cost and quality.

9. Reducing costs requires more than superficial changes. Whichever direction the state chooses to go, the changes in health care delivery that will be required to address the rising costs of Medicaid will have a direct impact on patients and providers.

10. With the passage of federal health reform, investments in public health initiatives that reduce the incidence of preventable chronic diseases may become more attractive. The savings and benefits that result from such initiatives are now more likely to accrue back to the entity making the investment: government.

11. The federal health reform legislation provides numerous financial incentives for states to experiment with cost-saving and care-management programs. The state of Kansas – including policymakers and stakeholders – will need to decide soon which direction it wants to take and which demonstration project grants it wants to apply for.